

Chapter One (in *The Sexual Politics of Disability: Untold Desires*, Tom Shakespeare, Kath Gillespie-Sells & Dominic Davies (1996) Cassell, pp 1-15)

One

Introduction

The changing disability context

This is the first book to look at the sexual politics of disability from a disability rights perspective. We attempt to explore the emotional and sexual experiences of disabled people in a variety of key areas, relying predominantly on the verbatim accounts of disabled people themselves. No book of this kind has previously been available, and the material that has existed has not reflected the changing context of disability (e.g. Lancaster-Gaye, 1972; Griffiths, 1975; Robinault, 1978).

Since the mid 1970s, disabled people in Britain have begun to challenge their isolation and marginalization, and develop radical responses to the situation in which they have found themselves. This development, centred on the self-organized movement of disabled people, is paralleled with experiences around the world. Disabled people are speaking for themselves, demanding civil rights, and refusing to tolerate exclusion and silencing. This process has been extensively documented elsewhere (Pagel, 1988; Driedger, 1989; Coleridge, 1993; Hasler, 1993), and is a vital background to this volume. Here we have space only to highlight a few of these political issues, but we will return to the changing political context of disabled people's personal lives in the final chapter.

A key milestone was the formation of the British Council of Organisations of Disabled People, in 1981. BCODP has now become the leading representative group in Britain, and has spearheaded the national campaign for anti-discrimination legislation (Gooding, 1994). Locally, many areas have developed coalitions of disabled people and Centres for Integrated Living, in order to put disability issues on the agenda. Particularly important to these grass-roots contexts is the arena of

community care: disabled groups have campaigned for participation, consultation, and control, and specifically have worked towards establishing direct payments and self-operated personal assistants schemes, a means whereby people with severe impairments can live independently in the community.

These initiatives, including the national campaign for civil rights, the various campaigns for accessible transport and housing, and the campaigns against the patronizing fundraising techniques of charities and telethons, have all seen the deployment of a new tactic. Disabled people have begun using direct action -blockades, protests, pickets, and occupations -in order to assert their presence and publicize their demands. Here, in its most symbolic form, disabled people are 'doing it for themselves', and issuing a radical challenge to the status quo of British society (Shakespeare, 1993).

The diversity of practical, social and political developments all share a common theoretical underpinning. Known as the 'social model', this is an analysis of the experiences of disabled people which was pioneered by the radical network Union of the Physically Impaired Against Segregation in the early 1970s, and given academic credibility by the work of Vic Finkelstein (1980) and later Michael Oliver (1990). The social model has been called the 'big idea' of the disability movement (Hasler, 1993). Quite simply, this challenges the traditional view of disability as a medical tragedy, and replaces it with a view of disability as a social oppression. In sociological terms, this is about arguing that disability is socially constructed not biologically determined. Just as feminists (e.g. Oakley, 1972) have distinguished biological sex (male/female) from social gender (masculine/feminine), so disability radicals distinguish impairment (physical) from disability (social).

The social model suggests that people with impairment are disabled by society, not by our bodies. The main 'problem' of spinal injury is not a failure to walk normally, but a failure to gain access to buildings if one uses a wheelchair. The difficulty of deafness is not inability to hear, but the failure of society to provide Sign Language interpretation and to recognize deaf people as a cultural minority (Gregory and Hartley, 1991). This radical re-interpretation shifts the site of the problem from

the disabled person, whose body does not work, to society, which is unprepared to accept disabled people. People with impairment are disabled by the twin processes of discrimination (Barnes, 1991) - economic, social and physical -and prejudice (Barnes, 1992; Shakespeare, 1994a) – cultural, attitudinal, psychological. In Chapter 1 we will explore some of the barriers that disable people, and their consequences for individuals with impairment.

The social model of disability and the self-organized movement of disabled people are critical initiatives for at least two major reasons. First, by identifying the problem and the solution and by political action to bring about change, the new radicalism offers the best hope of practical improvements in disabled people's lives. Second, and as important, is the way that the new ideas and actions contribute to a positive sense of disability identity, of collective strength, and of pride as disabled people. Slogans such as 'Rights not charity' and the empowerment evidenced in collective action and self-organization enable individuals to move from a negative self-image to a positive self-image, to change from self-blame and self-pity to anger and self-confidence. Given that self-love, confidence and assertiveness are critical elements in a successful emotional, sexual and romantic life, then these developments will also increasingly impact on disabled people's experience of love and relationships. As we will discuss in the chapter on barriers, and the subsequent chapter on identity, there is still a long way to go, but this book charts some of the positive aspects of the contemporary situation, as well as the persisting problems.

Sexuality as an absence

There is quite an industry producing work around the issue of sexuality and disability, but it is an industry controlled by professionals from medical and psychological and sexological backgrounds. The voice and experience of disabled people is absent in almost every case. As in other areas, disabled people are displaced as subjects, and fetishized as objects. A medical tragedy model predominates, whereby disabled people are defined by deficit, and sexuality either is not a problem, because it is not an issue, or is an issue, because it is seen as a problem. Disabled anthropologist Robert Murphy has written: 'The sexual problems of the

disabled are aggravated by a widespread view that they are either malignantly sexual, like libidinous dwarfs, or more commonly, completely asexual, an attribute frequently applied to the elderly as well' (Murphy, 1987: 83).

The American writer Milton Diamond has explored the unwillingness of society to engage with disabled people's sexuality: he suggests that professionals view sexual issues as of lower concern than other rehabilitation priorities. Often agencies avoid the subject because they are concerned with performance targets, and worried about their image. Families also try to ignore the issue of sex: 'While they recognize that these are valid issues, they generally wish the sexual concerns to be ignored; they want them to sort of "go away", since they are ill at ease dealing with them, and don't really know how to handle the issues' (Diamond, 1984: 210). Families are torn between promoting normalization, and causing difficulty (Diamond, 1984: 211):

On the one hand, they want to consider the handicapped family member like everyone else and thus allow all opportunities. On the other hand, they don't want to, as they consider it, raise false expectations and hopes. Lastly it is difficult for the family to recognize that children or parents can be sexual. Regardless of age, elderly parents are often considered 'beyond it' and children 'not yet ready'.

Contrasting several qualitative studies of disabled people's lives is instructive in terms of discourses which operate around sexuality. Gillian Parker's study of marriage and disability, *With This Body*, argues that discussion of marriage is absent from work on disability (Parker, 1993: 4). However, her own book manages to discuss aspects of marriage, relationships, and caring while almost completely ignoring issues of sex and love. There are only three references to sexuality or sexual relationships in the study, the longest discussion of which extends to less than three pages, out of 129. Long-term gay or lesbian relationships are excluded from the research. Theoretical conclusions about the impact of impairment and/or caring role on masculinity or femininity are not developed. Julie Seymour's similar paper 'It's different from being loving': disablement, caring and marriage' also focuses on caring and

coping in a way which ignores sexual aspects of relationships, as well as non-conventional and non-heterosexual liaisons (Seymour, 1994). We argue that the effect of this focus on care is to de-sexualize disabled partnerships.

Jenny Morris, author of *Independent Lives*, a study of disabled people and independent living, is a disabled freelance researcher and activist. While her book (Morris, 1993a) is again not specifically about sex and love, she does manage to include appropriate discussion of relevant issues, and to incorporate lesbian and gay experience: for example, there are references to issues of privacy, experience of homophobia, and experience of abuse. While Morris cannot be said to have dealt with the issues fully, they are at least considered alongside other concerns, and the validity of disabled people's sexual expression is recognized. Her most recent book, a collection of articles by disabled women on aspects of disability and feminism (Morris, 1996), illustrates another problem: contributions explore sexual abuse, and also genetic screening, but do not discuss the wider issue of sexuality and relationships. Such an approach contributes to constructing sex and reproduction as predominantly problematic for disabled people.

Just as disability research, traditional and radical, has tended to underplay sexuality, so work on gender and sexuality has historically ignored disabled people's experience of these issues. Yvon Appleby has criticized Adrienne Rich's influential notion of compulsory heterosexuality for failing to appreciate the different context for disabled women (Appleby, 1993: 266):

The pressures on disabled women to engage in heterosexual practice operate differently from those to which able-bodied women are subjected. Disabled women are particularly at risk of (hetero) sexual abuse and rape, while they are generally not considered to have any sexual feelings or functions (motherhood) and are therefore considered to be less than female.

In recent years it has been disabled feminists who have rectified the omissions, and shown the specific issues that relate to disabled women,

and the potential clash of priorities with non-disabled women (Morris, 1989, 1991; Begum, 1992; Keith, 1992).

However, it would be fair to say that issues of sexuality, relationships, and personal identity have also been neglected within the disability studies perspective, and it is this absence which we aim to rectify. It is not just that 'the personal is political', but also that a key area of disabled people's experience has been largely ignored. Both academics and campaigners have de-prioritized sex and love. The American disabled feminist Anne Finger argues that the disability rights movement has not put sexual rights at the forefront of its agenda: 'Sexuality is often the source of our deepest oppression; it is also often the source of our deepest pain. It's easier for us to talk about - and formulate strategies for changing - discrimination in employment, education, and housing than to talk about our exclusion from sexuality and reproduction' (Finger, 1992: 9).

While disability studies research has applied social model perspectives! to a range of public arenas - schools, workplaces, politics, and the environment -it has failed to problematize sex and relationships. This is despite the fact that disabled people find this area among the most important of the problems with which they have to deal. The following anecdote highlights this dissonance. Professor Michael Oliver, a pioneering disability studies academic, wrote an article for *The Guardian* entitled 'I truly believe that my disaster was the best thing that ever happened to me', which was later reprinted in the *Spinal Injuries Association Newsletter* (no. 23, 1982). In this article, Oliver promotes a social model perspective by suggesting that impairment does not equate with tragedy, and that the main barriers are social, not physical. While he was upbeat about the effect of his paralysis in the article, and also in the subsequent television programme *Where There's Life*, other members of the Spinal Injuries Association were more sceptical. In particular, one correspondent wrote in as follows (*Spinal Injuries Association Newsletter*, 1982: 16):

From my own point of view, it can only be classified as a tragedy. My accident has completely destroyed my freedom and choice. ...I was amazed when Michael and his wife suggested

that married life is the same as an ordinary couple's life, e.g. they share the house bills. Come on and admit the truth. Surely the sexual implications must bother other tetras and paras even if Michael failed to mention them, or did he feel too embarrassed whilst being televised? To be totally honest, sex is one thing that torments my mind more than any other aspect of paralysis. In fact, for me, it has taken over my life as a constant obsession. A person without sexual feelings cannot be normal.

There is a conspicuous silence on personal issues within the disability studies literature, although Jenny Morris's book *Pride Against Prejudice* comes closest to discussing disabled people's subjective experiences (Morris, 1991). The absence is partly explained by the oppressive tradition of individualizing disability within the medical tragedy model. There was an entirely explicable desire to move away from individual lives towards structural and political analysis of the discrimination faced by disabled people. However, we feel it is now time to explore the personal and sexual politics of disability because this adds a vital dimension to our understanding of the social model and of disabled people's experience.

While sexual politics have generally been neglected within disability studies, there has been some awareness of gender issues. This has led to two related arguments, for which the evidence is patchy. First, it is suggested that disability studies has constructed a 'false generic', talking about 'disabled people' when in fact it is talking about 'disabled men'. Thus Oliver quotes Deegan and Brooks (Deegan and Brooks, 1985:1):

Despite the attention given to disability in general and certain impairments in particular, one category within the disabled population has received little recognition or study: women. Like many social change movements, the disability movement has often directed its energies towards primarily male experiences.

and Jenny Morris provides evidence that some publications have presented a false generic (Morris, 1993b: 90). However, the literature shows that there is not a straightforward gender bias, despite the predominance of male academics. Feminist critiques of mainstream, or

male stream, theory in other areas suggests that 'people' are falsely constructed from a narrowly male model, hence the need to fill in the gaps and explore women's experiences. In the case of disability studies, it is not necessarily that a false generic has been the prevailing model. As we have suggested above, disability studies has downplayed the personal and focused on the structural. It seems almost as if disability studies has reproduced the wider split between public and private with which students of gender studies are familiar. Thus we learn much about the public lives of men ,and women, but next to nothing about the private and personal lives of men or women. In terms of the research and investigation of these issues, we would argue that there is a considerable amount of work on disabled women, but hardly any on disabled men (see Campling, 1979, 1981; Deegan and Brooks, 1985; Fine and Asch, 1988; Saxton and Howe, 1988; Morris, 1989; Lonsdale, .1990; Keith, 1994). Women, working predominantly within feminist contexts, have quite rightly explored issues of sexuality imagery, gender identity, and relationships, in relation to women, while men have perhaps concentrated on issues such as employment, discrimination, housing, income, and other material social issues in relation to disabled people as a whole. Michael Oliver's monograph (1990) contains eight references to women in the index, and nine to sexism, but none to men. The effect of this is that disabled men's experience is under-represented, with only one major article on disabled masculinity (Gerschick and Miller, 1995). Furthermore, the experience of black and ethnic minority disabled !then and women, and of lesbian and gay disabled people, is similarly u1lder-explored. We hope in this study to contribute to the understandings of masculinity and sexuality, although we acknowledge that we have not succeeded in offering insight into issues of 'race' and ethnicity.

The second argument is a product of the omissions discussed, and is that the prevailing view of gender identity is limited and simplistic, for example in the following quotation (Fine and Asch, 1985: 6):

Whereas disabled men are obliged to fight the social stigma of disability, they can aspire to fill socially powerful male roles. Disabled women do not have this option. Disabled women are perceived as inadequate for economically productive roles (traditionally considered appropriate for males) and for the

nurturant, reproductive roles considered appropriate for females.

As we will argue in Chapter 2, disabled people's gender identity is more complex and more varied than this stereotyped view indicates. Some women feel liberated from social expectation as a result of impairment; some men feel doubly inferior. The tendency to highlight the particular problems of disabled women obscures the strength and resistance of disabled women, especially those women who have become leaders of the disability movement: Jenny Morris writes that this notion of 'double disadvantage' has the effect of making her feel like a victim (Morris, 1996: 2). Masculinity and femininity are in a process of transitional change within Western societies, which makes it difficult to generalize about the strategies of individual disabled men and women. The extent of denial, compensation, social acceptance, and the consequences in terms of role and identity are not clear cut.

The two debates we have highlighted indicate the importance of new thinking on the sexual politics of disability. There is a lack of empirical information, and there is a lack of theoretical analysis. This work explores the neglected area of disability and sexuality, and establishes it as a key political and sociological issue. We do not aim to provide a comprehensive account of disabled people's experiences of sex and love, but we do hope to put the issue on the agenda, and to raise questions about sexual politics. The prevailing attitude, central to the prejudice faced by disabled people is that disability and sexuality are incompatible: we aim to demolish this myth in the following pages.

Disabled people as asexual

The neglect of sexual politics within the disability movement, and its absence within disability literature, mirrors the wider attitudes of society to disabled peoples sexuality. Jenny Morris quotes Pam Evans's list of assumptions held about disabled people by non-disabled people. These attitudes include a number which are explicitly focused on our sexual difference (Morris, 1991: 20ff.):

That we are asexual, or at best sexually inadequate.

That we cannot ovulate, menstruate, conceive or give birth, have orgasms, erections, ejaculations or impregnate.

That if we are not married or in a long-term relationship it is because no one wants us and not through our personal choice to remain single or live alone.

That if we do not have a child it must be the cause of abject sorrow to us and likewise never through choice.

That any able-bodied person who marries us must have done so for one of the following suspicious motives and never through love: desire to hide his/her own inadequacies in the disabled partner's obvious ones; an altruistic and saintly desire to sacrifice their lives to our care; Neurosis of some sort, or plain old fashioned fortune-hunting.

That if we have a partner who is also disabled, we chose each other for no other reason, and not for any other qualities we might possess. When we choose 'our own kind' in this way the able-bodied world feels relieved, until of course we wish to have children; then we're seen as irresponsible.

It has been argued elsewhere that prejudice and stereotype play a critical role in disabling social relations (Shakespeare, 1994a). In the realm of sex and love, the generalize assumption that disability is a medical tragedy becomes dominant! and inescapable., In modern Western societies' sexual agency (that is, potential or actual independent sexual activity) is considered the essential element of full adult personhood, replacing the role formerly taken by paid work: because disabled people are infantilized, arid denied the status of active subjects, so consequently their sexuality is undermined. This also works the other way, in that the assumption of asexuality is a contributing factor towards the disregard of disabled people. There are clear parallels with the situation of children and older people. Beth, a professional woman with MS, told us:

'I am sure that other people see a wheelchair first, me second, and a woman third, if at all. A close friend assumed that, for me, sex was a thing of the past. I think that this is a view shared by the majority. It may have little reality, but influences my self-image.'

Our respondents report a failure of professional services to take their sexuality seriously, and an absence of work around sexuality in the disability movement itself. Many social groups face oppressive assumptions about their sexuality - for example, the image of predatory black masculinity, or promiscuous gay male sexuality - but we would argue that stereotypes of disabled people are among the most deep-seated and debilitating. Just as public displays of same-sex love are strongly discouraged, so two disabled people being intimate in public will experience social disapproval.

Stereotypes of disability often focus on asexuality, of lack of sexual potential or potency. Disabled people are subject to infantilization, especially disabled people who are perceived as being 'dependent'. Just as children are assumed to have no sexuality, so disabled people are similarly denied the capacity for sexual feeling. Where disabled people are seen as sexual, this is in terms of deviant sexuality, for example, inappropriate sexual display or masturbation. Derogatory stereotypes, concerning for example blindness, are typical of this tendency. The assumption of essential abnormality is also reflected in traditional academic work: for example, the American sociologist Lemert, who wrote that 'Little is known of the sex life of the single blind person' (Lemert, 1951: 34).

While there is an academic and political silence, there is evidence that ordinary disabled people are concerned about these issues. For example, *Disability Now* is a newspaper published by SCOPE but read very widely in the disability community, which devotes considerable space to issues of sex and relationships. The 'Share Your Problems' column discusses the difficulties of loneliness and sexual fulfilment, there are personal advertisements on the classified page, and each February there is an extended feature of relationships. This seems due to reader demand: from the letters published on the advice page, it is clear that many disabled people find the issue of sex and relationships to be among the most problematic and distressing. However, *Disability Now* is to be praised for the range of pieces it has published, which include features on lesbian and gay couples, dating agencies, and even sex shops, as well as the more traditional 'happy ever after' stories.

SCOPE has also published the research report *Disabled in Britain*, taken from a postal survey of 1,568 disabled people. The discussion of social relationships concludes with this comment (Lamb and Layzell, 1994: 21): ,

There is an unspoken taboo about relationships and disabled people. Disabled people's sexual and emotional needs are rarely included in any discussion or representation in everyday life, whether this is in the papers and magazines we read, or the movies we watch. This reinforces the public's attitudes and expectations towards disabled people as seeing them as 'sick and sexless' rather than participating in full sexual and family relationships. It is perhaps one of the most pernicious ways in which society has blanked out disabled people from a fundamental area of social life.

This book

There has been little previous investigation of disability and sexuality, and therefore we have had to start from scratch with this research. However, there is a burgeoning disability studies literature from which we have drawn, including a growing field of disabled feminist writing. We have also been able to use some social policy findings to give a context to our discussion. But the main material in this book is drawn from the accounts of disabled people themselves, from our own research.

We have talked to forty-two disabled people, aged from twenty to late fifties, from many different backgrounds. Our sample was gathered via advertisements in disability publications, such as the newspaper *Disability Now*, and newsletters and journals of the disability movement, lesbian and gay publications, plus word of mouth and via a snowball process. As a consequence of the authors' own biographies there is a bias towards respondents from Tyneside or London, or who are lesbian, gay, or of Irish origin. We tried to ensure that our sample was approximately representative of minorities within the movement, although this was only partially successful. We are conscious that older disabled people, disabled young people, black and ethnic minority disabled people, and

people with learning difficulties have not adequately been represented within our research.

These factors mean that we would counsel caution in reading this book as fully representative of the disabled population as a whole. It is at best a cross-section of the disabled community. With over six million disabled people in Britain, it is very dangerous to generalize from a small sample, and it would have required time and resources unavailable to us in order to achieve a sociologically representative group of respondents. However, we feel that this is a useful contribution to the literature on disability, and it begins to fill a major gap in terms of disability and sexuality. While many of our respondents were significantly more empowered, more mobilized, and more vocal than perhaps is typical of the disabled population, this research nevertheless indicates the potential that exists for disabled people to lead fulfilled and sexual lives. The silent presence of the millions of disabled people who are denied the possibility of sexual expression, who are incarcerated in institutions or sheltered by their families, underpins the optimism of this book. We would strongly argue that the testimony of our respondents indicates the possibilities which exist for all disabled people. We do not think that the optimism and pride which comes through these accounts is necessarily typical of the whole disabled population, but we do think it shows that the barriers to sexual and emotional fulfilment do not reside in the impairments of the body but in the restrictions of our society. We look forward to the day when the positive experiences which many of our respondents have shared become the norm for disabled people as a whole.

We used a variety of approaches to access the experiences of our respondents: some people wished to be interviewed, and we used a semi-structured interview format, tailored in some cases to the particular issues which people wanted to explore (for example, we developed separate schedules in the areas of parenting, and of HIV/AIDS). Interviews generally lasted from an hour to ninety minutes. Other people answered a questionnaire, and still others wrote letters to us, wrote their own accounts, or tape-recorded their experiences as they wished. In all cases we have respected the confidentiality and anonymity of respondents' accounts, and have made no more changes to the texts than

necessary to improve the appearance and flow of the accounts. We have been very influenced by Tim Booth's discussion of the power and importance of oral narratives, although we have not gone as far as him in terms of rewriting responses to convey better the meaning intended (Booth, 1996). Again, Ken Plummer's recent book *Telling Sexual Stories* (Plummer, 1995) has been a great inspiration to us, as to other researchers in this field, and while we have consciously minimized our own interpretation and analysis of the types of narratives which have emerged, the stories are undoubtedly susceptible to the method of investigation pioneered in Plummer's work.

The book is divided into six chapters. 'Barriers to being sexual' discusses external and internal obstacles to disabled people's sexual expression, including the lack of sex education. 'Identity and imagery' is about feelings and about appearance. 'Sex and relationships' discusses just that, and briefly explores the subject of parenting, although proper coverage is outside the scope of the book. 'Bad sex' discusses a continuum of power issues, from prostitution to abuse. 'Double the trouble?' presents the views of lesbian, gay and bisexual disabled people, and 'Making a change' shows how disabled people are resisting oppression and moving forward to demand sexual rights. Between chapters there are personal accounts, which give direct access to disabled people's views, and illustrate key dimensions of the sexual politics of disability: they do not necessarily represent the authors' perspectives.

Caroline

A year or two ago, *Disability Now* had a feature on sex aids. In the edition was a letter from an irate reader expressing disgust and that people should see their doctor for advice on sex. That made really angry, and I was pleased to see my own reply in a edition. My view was that I go to my doctor about medical matters as far as I'm concerned, sex is not medical. I commented that disabled people can easily obtain information on sex by picking up a women's magazine, so why shouldn't disabled people also have access to information in the same way?

I still feel strongly about this issue, particularly after an encounter with a doctor. Because of painful joints and muscles, sex is, at the very least, pretty uncomfortable. I was due to attend a pain clinic and I was asked to fill in a detailed questionnaire. One question asked whether pain prevented enjoyment of sex, so I answered 'Yes'. When I saw the doctor, he noticed this response and said that it must be because I don't love my husband. I was horrified! I was so upset that I have never even told my husband what the doctor said -I haven't told anyone until now. Sadly, every time I find I am unable to have sex because of pain in my back and hips, the idea crosses my mind that perhaps I don't love my husband. As a result of that day, I have never mentioned my problem with sex to a doctor. The medical profession is not, in my opinion, the appropriate source of wisdom regarding sex.

I have found a booklet published by Young Arthritis Care (*Our Relationships and Sexuality*) helpful. I have also been in touch with SPOD (Sexual Problems of the Disabled) -but I would still prefer to set information about sex freely available in magazines.

I met my husband-to-be from a hospital bed, so he was fully aware of my impairment from the beginning. Even so, I do find it difficult to express my sexuality with the man who has just helped me to get up from a chair or taken off my socks.

We have been married for eight years now, and in all that time no one has ever asked me the usual question: 'When are you going to have children?' It's as though everyone assumes a disabled woman won't want

children. In a sense it's true -I don't want any. However, I am aware that I am using a defence mechanism. It is easier to say that I don't really like children than to admit that I always wanted babies, but decided not to have them because I know I would not get the necessary practical support. To acknowledge what I feel I have been denied is almost too painful to think about. It's safer to tell myself that I don't want to have children anyway. On the subject of families, I stopped going to the family planning clinic because I felt so out of place. The waiting room was always full of 'young girls', and I felt conspicuous with my sticks (I couldn't go in my wheelchair because the ramp was too steep!). Usually I feel strong as a disabled person, but hospitals and health centres have an adverse effect.

I'd like to be able to declare that, as a disabled woman, I have a happy and fulfilled sex life. Sadly, however, that is not true. Although everyone can now say 'condom' without any difficulty or embarrassment, the idea that disabled people have sex is still taboo. My dream is to open a magazine and think 'I could try that', instead of saying 'You must be joking -I can't even look up at the chandelier, let alone swing from it!' Information is power, and disabled people still don't have enough of it.